BEFORE THE PERSONNEL APPEALS BOARD

STATE OF WASHINGTON

JERRIANN POMERINKE, Appellant, v. DEPARTMENT OF SOCIAL AND HEALTH SERVICES, Respondent.	Case No. DEMO-01-0034 FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER OF THE BOARD

I. INTRODUCTION

1.1 **Hearing.** This appeal came on for hearing before the Personnel Appeals Board, GERALD L. MORGEN, Vice Chair, and RENÉ EWING, Member. The hearing was held at Lakeland Village in Medical Lake, Washington, on January 14 and 15, 2003. WALTER T. HUBBARD, Chair, did not participate in the hearing or in the decision in this matter.

1.2 **Appearances.** Appellant Jerriann Pomerinke was present and was represented by Dennis Clayton, Attorney at Law. Donna Stambaugh, Assistant Attorney General, represented Respondent Department of Social and Health Services.

1.3 **Nature of Appeal.** This is an appeal from a disciplinary sanction of demotion for neglect of duty, insubordination, gross misconduct and willful violation of published employing agency rules and regulations. Respondent alleged that Appellant failed to properly administer a prescribed pain medication to a resident of Lakeland Village.

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1.4 **Citations Discussed.** WAC 358-30-170; Baker v. Dep't of Corrections, PAB No. D82-084 (1983); McCurdy v. Dep't of Social & Health Services, PAB No. D86-119 (1987); Rainwater v. School for the Deaf, PAB No. D89-004 (1989); Skaalheim v. Dep't of Social & Health Services, PAB No. D93-053 (1994).

II. FINDINGS OF FACT

2.1 Appellant Jerriann Pomerinke is an Attendant Counselor 1 and permanent employee for Respondent Department of Social and Health Services. Appellant and Respondent are subject to Chapters 41.06 and 41.64 RCW and the rules promulgated thereunder, Titles 356 and 358 WAC. Appellant filed a timely appeal with the Personnel Appeals Board on November 26, 2001.

2.2 Appellant began her employment as a Registered Nurse 2 at Lakeland Village in November 1997. Prior to her employment at Lakeland Village, Appellant had experience working as a nurse in the private sector, dating back to 1990.

2.3 As a registered nurse, Appellant was obligated to adhere to WAC 246-840-700 which outlines the Standards of Nursing Conduct or Practice. Appellant also had a duty to provide effective and quality nursing care based on client needs and an obligation to ensure that the administration of medications was done in compliance with standards of nursing practices and in accordance with Washington State Law and professional nursing standards.

2.4 Lakeland Village has adopted nursing procedures which outline the administration of medications to residents. Appellant was familiar with these medication procedures and received training on these procedures in December 1997 and in April 1999.

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2.5 Appellant was a medication nurse and was responsible for appropriately preparing, administering and documenting medications given to residents on cottages housed in Program Area Team (PAT) 2. Appellant was the team leader for the day shift (6:45 a.m. to 3 p.m.), and she was responsible for the care of 30 clients. In this capacity, Appellant was also responsible for making daily assignments, making assessments of acute ongoing issues, coordinating interdisciplinary areas of client care and participating in monthly medication assessments between the pharmacy and physicians.

2.6 Appellant has no history of formal disciplinary action, however, she received a letter of reprimand dated October 25, 2000 for her failure to correctly administer medications and for leaving narcotics unattended. Appellant's superiors, Rhonda Eik, Registered Nurse 4, and Kathryn Montague, Developmental Disabilities Administrator 2, directed Appellant to directly observe the actual ingestion of medications by clients. Appellant was clearly put on notice that medication errors were considered serious and would be grounds for discipline. In addition, they encouraged Appellant to contact the Employee Advisory Service if she felt that personal problems were interfering with her work performance.

2.7 Alice was a resident of a cottage on PAT 2. Sometime in late June, Alice fell and broke her leg. Alice's physician prescribed hydrocodone, a schedule 2 narcotic, for pain and discomfort. hydrocodone is known to cause drowsiness after being ingested. The medication was administered to Alice on an "as needed only" basis when she communicated she was in pain.

2.8 On July 6, 2001, at approximately 7 a.m., Appellant was administering a number of medications to Alice, including a hydrocodone tablet. Appellant poured the hydrocodone pill, as well as a number of other medications, in a pudding cup which she used to facilitate Alice's swallowing of the pills. Because Alice's weight was an issue, Appellant fed her approximately half

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the pudding in the cup. Appellant subsequently disposed of the cup with the remaining pudding into the trash. Appellant failed to determine whether there were any pills remaining in the cup. Appellant made a notation in Alice's Medication Flow Sheet that the hydrocodone tablet had been administered to Alice.

2.9 At approximately 8:30 a.m., Laboratory Technician Laurie Cue-Perry drew blood from Alice. Staff had a concern that Alice was not receiving the hydrocodone pills and the blood test was specifically ordered to determine whether the hydrocodone was in Alice's system.

2.10 At 9 a.m., Appellant checked on Alice's condition. Appellant then made a second notation on Alice's medication record that the hydrocodone had taken effect.

2.11 The laboratory results of Alice's test showed that there was no detectable hydrocodone in her system.

2.12 The results of Alice's blood test were reviewed by Kathryn Montague, Developmental Disabilities Administrator 2. As a result, she met with Appellant to conduct a fact finding investigation on July 17, 2001 to determine what occurred on July 6. On July 18, Ms. Montague initiated a Conduct Incident Report against Appellant which read:

> On July 6, 2001, you determined that Alice ... was in pain. Your documentation on the medication flow sheet indicates that you gave Alice 10 mg of [hydrocodone] at 7:00 a.m. and that it was effective at 9:00 a.m.
>
> A blood test was performed on 7/6/01 at 8:30 a.m. The result of this test indicated that there was no medication (hydrocodone/Norco) in her system.

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2.13 On July 27, 2001, Appellant submitted a written response to the CIR describing her actions with Alice on the morning of July 6. Appellant did not dispute that Alice had not ingested the hydrocodone.

2.14 Alan Kertes was the Superintendent of Lakeland Village when the incident with Alice occurred. Mr. Kertes assigned the management investigation to Delores Shack. Ms. Shack had been Lakeland Village's Nurse Practice Duty Administrator since January 2001. Ms. Shack was experienced in conducting investigations, however, her nursing review of Appellant was the first she had conducted at Lakeland Village. Ms. Shack completed her written report sometime around August 6, 2001.

2.15 Based on a request from Appellant's union representative, Mr. Kertes reviewed the rate of medication errors made by all other nurses in PAT 2 during a one year period. Mr. Kertes compared this rate to the medication errors made by Appellant with client Alice for a six month period. His review of Appellant's error rate was also limited to a review of mistakes Appellant made with one medication. After analyzing the data, Mr. Kertes concluded that Appellant's error rate was five times the combined error rate of all the nurses on PAT 2.

2.16 On September 11, 2001, Mr. Kertes made a finding of misconduct.

2.17 Mr. Kertes was scheduled to retire in September 2001. Terry Madsen had been identified as the new superintendent. Prior to Mr. Kertes' departure, Mr. Madsen began to transition into the superintendent position. As a result, Mr. Madsen familiarized himself with the circumstances regarding Appellant's medication error on July 6 by reviewing the CIR packet and Appellant's response. Mr. Madsen also participated in Appellant's CIR hearing.

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2.18 Mr. Kertes and Mr. Madsen subsequently met to discuss the appropriate level of discipline. Because Mr. Kertes' retirement would become effective prior to the letter of discipline being issued, he made a recommendation to Mr. Madsen that Appellant be demoted from a nursing position to position where she had no responsibility for administering medications to clients. Prior to making his recommendation, Mr. Kertes reviewed Appellant's employment history, the October 25, 2000 letter of reprimand, and information that showed that Appellant's error rate was five times higher than other nursing staff. Mr. Kertes also reviewed the report from Delores Shack, however, he discounted the majority of its contents because they went beyond the July 6, 2001 incident and were outside the scope of the CIR.

2.19 Mr. Kertes based his recommendation on his paramount concern for the clients and his belief that Appellant could not be trusted to properly administer their medications. Mr. Kertes and Mr. Madsen discussed the possibility of placing Appellant in a lower level nursing position, reducing her pay or suspending her, however, they did not believe that these sanctions would provide the protection they felt the clients needed.

2.20 On September 16, 2001, Mr. Madsen was officially appointed as the Superintendent of Lakeland Village. By letter dated October 29, 2001, Mr. Madsen, in his capacity as the appointing authority, informed Appellant of her demotion from her position as a Registered Nurse 2 to an Attendant Counselor 1 position. The demotion became effective November 16, 2001. Mr. Madsen charged Appellant with neglect of duty, insubordination, and gross misconduct for her failure to properly administer pain medication to resident Alice.

2.21 Mr. Madsen based his ultimate decision to demote Appellant to a non-nursing position after weighing 1) Mr. Kertes' recommendation for demotion, 2) Appellant's failure to ensure that Alice swallowed her medicine, 3) Appellant's employment history with Lakeland Village, which included

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a letter of reprimand for medication errors, and 4) the CIR packet and Appellant's response to the CIR. Mr. Madsen was not convinced that the agency could rely on Appellant to continue in a position as a nurse, because all nursing positions had medication administration responsibilities. He concluded because the primary mission at Lakeland Village is to provide care and services to persons with developmental disabilities, the institution was best served by placing Appellant in a non-nursing position. Mr. Madsen determined that demotion to an Attendant Counselor 1 position was the best preventative measure to ensure the well-being of clients because Appellant would have no control over the administration of medication.

2.22 Appellant testified that at the time of the incident she was experiencing a number of personal problems, and that she used alcohol to relieve her stress. However, Appellant did not make her superiors aware of her personal problems or of her alcohol addiction, nor did she ask for time off from work to seek professional help.

III. ARGUMENTS OF THE PARTIES

3.1 Respondent argues that demotion is the appropriate sanction based on Appellant's failure to properly administer hydrocodone, a schedule 2 narcotic, to client Alice. Respondent asserts that it will never be known whether Alice, a vulnerable individual, received all her medications or whether she was in pain. Respondent argues that Appellant used poor judgment when she failed to verify whether Alice had swallowed all of her pills, and that the blood test confirmed that Alice had not received the hydrocodone. Respondent asserts that Mr. Kertes and Mr. Madsen engaged in appropriate communication regarding the level of discipline. Respondent argues that Appellant's problems, which she failed to reveal at the time of the incident, do not mitigate her carelessness or poor judgment. Respondent argues that Appellant was an experienced nurse with extensive training in the administration of medications and that she had been previously reprimanded for medication

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errors. Respondent argues that Mr. Madsen's decision to demote was necessary in order to ensure the best care of clients by removing Appellant from a position where she administered medications.

3.2 Appellant asserts that she is a well-qualified and respected member of the local health care community and that she received very good evaluations at Lakeland Village. Appellant argues that there are significant mitigating circumstances that make a permanent demotion from her nursing position inappropriate. She argues that she was under a great deal of personal stress at the time of the July 6, 2001 incident and that she engaged in a pattern of excessive use of alcohol when not at work in order to cope with emotional problems. Appellant asserts that although she was not aware of it at the time, she is now aware that her problems affected her work performance as a registered nurse. Appellant asserts that she has corrected the problems that previously interfered with her professional performance. Appellant contends that even if disciplinary action was merited as a result of the incident on July 6, the disciplinary action should be reversed and/or modified.

IV. CONCLUSIONS OF LAW

4.1 The Personnel Appeals Board has jurisdiction over the parties hereto and the subject matter herein.

4.2 In a hearing on appeal from a disciplinary action, Respondent has the burden of supporting the charges upon which the action was initiated by proving by a preponderance of the credible evidence that Appellant committed the offenses set forth in the disciplinary letter and that the sanction was appropriate under the facts and circumstances. WAC 358-30-170; Baker v. Dep't of Corrections, PAB No. D82-084 (1983).

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4.3 Neglect of duty is established when it is shown that an employee has a duty to his or her employer and that he or she failed to act in a manner consistent with that duty. McCurdy v. Dep't of Social & Health Services, PAB No. D86-119 (1987).

4.4 Respondent has met its burden of proof that Appellant's failure to ensure client Alice swallowed her medication constituted a neglect of her duty to properly administer medications. Appellant was aware of her responsibility to properly handle and document medications prescribed to patients at Lakeland Village. Appellant's failure to fulfill this duty left at Alice risk of remaining in pain and discomfort.

4.5 Willful violation of published employing agency or institution or Personnel Resources Board rules or regulations is established by facts showing the existence and publication of the rules or regulations, Appellant's knowledge of the rules or regulations, and failure to comply with the rules or regulations. Skaalheim v. Dep't of Social & Health Services, PAB No. D93-053 (1994).

4.6 Respondent has met its burden of proof that Appellant was familiar with Lakeland Village's policy and procedure regarding the administration of medications to clients. Appellant's action when she failed to ensure that Alice swallowed the hydrocodone medication was not only negligent and inattentive, but constituted a willful violation of the policy and procedures on medication administration as well.

4.7 Insubordination is the refusal to comply with a lawful order or directive given by a superior and is defined as not submitting to authority, willful disrespect, or disobedience. Countryman v. Dep't of Social & Health Services, PAB No. D94-025 (1995).

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4.8 Appellant was given a lawful directive in the October 25, 2000 letter of reprimand that she observe clients swallow their medications. Respondent has met its burden of proof that failed to comply with a lawful order when she did not ensure that Alice swallowed the hydrocodone pill.

4.9 Gross misconduct is flagrant misbehavior which adversely affects the agency's ability to carry out its functions. Rainwater v. School for the Deaf, PAB No. D89-004 (1989). Flagrant misbehavior occurs when an employee evinces willful or wanton disregard of his/her employer's interest or standards of expected behavior. Harper v. WSU, PAB No. RULE-00-0040 (2002).

4.10 As a registered nurse, Appellant was responsible for ensuring that developmentally disabled residents under her care received appropriate medical treatment and care. Appellant's failure to ensure that she properly administered medication to Alice interfered with the primary function of Lakeland Village to care and provide services to clients, many of whom are unable to communicate their needs and wants. Appellant was previously given corrective action for failing to follow proper medication administration procedures, and her continued errors rise to the level of gross misconduct.

4.11 Appellant argues that her problem with alcohol abuse caused her poor judgment and performance as a registered nurse. However, we have consistently held that alcoholism is no defense to misconduct and does not diminish the fact that an employee should also be accountable for his or her actions. See e.g., Smigielski v. Dept. of Transportation, PAB No. DISM-01-0096 (2002); Bates v. Dept. of Licensing, PAB No. DISM-96-0082 (1997); Painter v. Dept. of Labor and Industries, PAB No. D94-034 (1995), affirmed Thurston Co. Super. Ct. No. 95-2-01406-0; Eliason v. Dept. of Revenue, PAB No. DISM-95-0050 (1997); Vaught v. Dept. of Social and Health Services, PAB No. DEMO-95-0025 (1995).

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4.12 Although it is not appropriate to initiate discipline based on prior formal and informal disciplinary actions, including letters of reprimand, it is appropriate to consider them regarding the level of the sanction which should be imposed here. Aquino v. University of Washington, PAB No. D93-163 (1995).

4.13 In determining whether a sanction imposed is appropriate, consideration must be given to the facts and circumstances, including the seriousness and circumstances of the offenses. The penalty should not be disturbed unless it is too severe. The sanction imposed should be sufficient to prevent recurrence, to deter others from similar misconduct, and to maintain the integrity of the program. Holladay v. Dep't of Veterans Affairs, PAB No. D91-084 (1992).

4.14 The serious breach of professional judgment demonstrated by Appellant's actions warrants a severe disciplinary action. After considering the seriousness of this incident, the potential harm to the clients, and Appellant's ongoing history of making similar errors, we conclude that Appellant should remain in a position where she has no responsibility for administering medication to patients. Therefore, Mr. Madsen's decision to demote Appellant to a non-nursing position is the appropriate sanction to prevent recurrence and maintain the integrity of the quality of care provided to clients at Lakeland Village.

4.15 However, we have reviewed the specifications for the classes of Attendant Counselor 1 and 2, and we concluded that demotion to an Attendant Counselor 1 is much too severe a penalty. In this case, we conclude that demotion to a position as an Attendant Counselor 2 will have the desired effect and convey to Appellant the seriousness of her medication error. Therefore, the disciplinary sanction should be modified.

V. ORDER

NOW, THEREFORE, IT IS HEREBY ORDERED that the appeal of Jerriann Pomerinke is modified, and she is demoted to a position as an Attendant Counselor 2.

DATED this _____ day of _____, 2003.

WASHINGTON STATE PERSONNEL APPEALS BOARD

_____
Gerald L. Morgen, Vice Chair

_____
René Ewing, Member

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